EOHHS Task Force Meeting
Monday September 28, 2015
1:00pm – 3:00pm
HP, Room 203
301 Metro Center Boulevard
Warwick, RI
Meeting Minutes

I. Welcome – Senator Izzo Thanks everyone for taking time from busy schedules, and hopes that today's agenda will touch on many very important items that are important for you all to be aware of, and to have feedback on.

II. Ongoing Initiative Updates
   a. Money Follows the Person, Jennifer Reid
      Jennifer came forward to talk about a grant that the state was awarded back in 2011. The MFP Federal Demonstration Act out of the ACA, primary purpose is that CMS using the funding and experience to assist states in rebalancing Medicaid-funded long term services and supports. In RI we decided to focus on Nursing Home setting. Transitioning beneficiaries in the system who are elderly, or living with disabilities. The state used the requirements under this grant to enhance the nursing home transition program already in place. WE capture data on the experience of those who make the transition to the home & community base-setting. . The state can then look at the data and experience to identify challenges and barriers as it relates to systems and policies. The criteria to participate is be in a nursing home for 90 days or longer. It is a seamless transition program, with access to a team to assist beneficiaries at every step (nurse, case worker, housing worker).

      For the duration of the time the person is in the demonstration, they consent to having quality of life surveys done, so as to capture experience pre transition, post transition and then 24 months after the transition. One of the big advantages to this grant is the ability for the state to claim additional FMAP for each person who receives services in this program, which goes into a 25% rebalancing account, not into general revenue.

      The MFP program has quarterly meeting steering committee that talks about the challenges and barriers, and actually maintaining the success of an individual. We have noticed that some individuals need some sort of 24 hour supervision, so trying to find supportive housing that would assist on this front is a major goal. The lack of community supports to keep people in their homes has been a major focus of the

discussion these past three and a half years. Looking now at areas for reinvestment of the rebalancing dollars: program evaluation through data analytics, workforce development, outreach opportunities, and housing. We really have one service that we will pay for under MFP, a tenancy service in conjunction with the state rental voucher, available to those coming out of Nursing Homes who need stabilization services to maintain their home while in a Nursing Home. A write up is being handed out to you all today, to provide more information on the activities underway (available upon request via email lauren.lapolla@ohhs.ri.gov). This program information is also available on the EOHHS website.

Questions
Q. Tenancy support, who will do it and what do you envision that entails?
A. Based on the guidance that CMS provided early this week, limited to tenancy stabilization services, how to access mass transition, financial management skills and teaching them those skills. The services in our pilot will be provided by the House of Hope, the same agency that issues the rental assistance program for adults.

b. Reinventing Medicaid Implementation Update, Matt Harvey
Mr. Harvey gives a presentation on some of the work ongoing, and the slides will be on the website shortly, and as always, available upon request at lauren.lapolla@ohhs.ri.gov

Questions:
Q. What does the project change, and complete status, mean on these slides?
A. The percent complete means how far into the tasks on the work plan are we done with. The change implies how much work has been done since last month's update.

Q. Regarding expected savings, is it all funds or general revenue?
A. General revenue.

Q. Are you differentiating within these savings infrastructure the administrative costs from direct care costs (i.e. in rate setting, of the $37 million projected savings how much is administrative infrastructure as opposed to direct individual)?
A. These are very good questions – you are right we should show full share impact vs. just general revenue. Next update can feature all funds reductions. The overwhelming majority are coming from the benefit spend side, paying less for services, not changing the benefit packages, but the burden of cost is changing.

Q. With behavioral health space, you mentioned you are seeking other providers for those being moved out of Eleanor Slater Hospital?
A. The theory of action is this we know that we have Medicaid beneficiaries who are currently living in Eleanor Slater Hospital who could be maintained in the community if there are providers with the capacity and willingness to participate to do that. There are others that are in an acute care hospital that do not need to be there clinically.

Q. Eleven, twelve years ago they moved people out of Eleanor Slater Hospital, were put in a Nursing Home for three or four days, and then into a ER when the Nursing Home couldn't handle the patient. I think you need to do a lot of research before you put someone into Long Term Care.
A. The intent is not to take people out of Eleanor Slater Hospital into a nursing home, or a home setting, but rather to the newer specialized group homes for those residents for whom it is clinically appropriate.

Q. I sent someone in the state to talk about doing assisted living for those with Behavioral Health issues, perhaps I should have sent them to you.
A. Please feel free to send anyone my way, happy to have conversations.

Q. Relating to the proposed changes in highest level of need. The document sent around was the projected savings would be $1million, do you know what that represents in terms of reduction of bed days, or number of people?
A. I don't know off the topo of my head but it was from extrapolation of bed days offset by an increase in spend at Nursing Home.

Q. On the description that most of the expected savings on rate setting is a reduction of actual benefit money, is that a cut in rate to those providing services?
A. We certainly hope so, the bulk of the reductions came from those to hospital and Nursing Homes, and some labs; certainly I think if you talk to representatives from either industry they are not thrilled with the reduction, but at this point we do not have access concerns.

Q. I know there were two stages, one for those with immediate impact, and those with longer term impact. Is the cut in rates reflective of a short or long term strategy, and if short, is there a strategy to deal with the changes going forward?
A. Short term. The Reinventing Medicaid work has two overlapping goals, a short term reduction in this fiscal year, and in the context of broader strategic plan, working to pay for value instead of volume,

etc. The initiatives on this sheet are some short term savings initiatives that line up a bit with where we want to go in the long term vision. The rate reductions do two things, but us on a more sustainable world of cost settings, and in terms of what that longer vision is, you will see over the next couple of months what the new Delivery System Reform Incentive Program (DSRIP) waiver will look like. DSRIP is a new 1115 waiver outlining where we want to go and how to get there. While these are smaller in scope may have more immediate impact, we are tracking them.

Q. One of the rate cuts was to the personal choice program, one that has had some trouble being managed, and I thought an issue with the managing it was reimbursement rates. What was the thinking there?
A. We are working this week to pull together a conversation with providers in that arena. We remain committed to the program, the savings initiative is on the administrative side. We made some assumptions about what we can do, and as we roll that out we will reach out in a transparent way.

Q. I am not familiar with the adults, but I am with the youth. It seems the literature would have you want to invest and then pull out the money, whereas you seem to have gone in another direction.
A. The kinds of changes we are proposing making are, for the most part, consistent with best practices in Medicaid agencies around the country. You are right that all else being equal the best way to be effective would be to make an investment in valuable programs and then cut off excess, but in this economic climate that is not feasible.

Q. When you make these decisions are you aware of how hard the providers have been hit? Is the cost factored in to this?
A. Yes, and not only is it important that we think about that, but we try to be as sensitive as possible so that we don't reduce much needed services to our members.

c. Integrated Care Initiative, Jennifer Bowdoin

After a hiatus we have decided to call together the Integrated Care Initiative Consumer Advisory Council, on October 19, for a full update and open feedback body.

We executed a memorandum of understanding a few months ago with CMS to kick off phase ii of the ICI, and now in the process of negotiating a contract with CMS and Neighborhood Health Plan (NHP), hopefully have that in a few months. Per CMS requirements we do need to be a bit mum on the details at this point. In the meantime, we can determine which specific details we can share with you; how

the integrated appeals and grievance process would work, some of the potential changes that would be a part of the Medicaid processes that are in line with Medicare; what our training strategy would be; more specific details around the call center, and our plan for working with and supporting how it impacts the ombudsmen. If you have other topics you are interested in, email Lauren (lauren.lapolla@ohhs.ri.gov) and we will explore what we can share.

We have an application out about the ADRC/SHIP work in the community. We are putting an RFP together on Ombudsman funding and will hopefully have that out in the next four weeks. It is $165K in the first year, about $155K in years two and three. We may extend the demonstration a few years and if that happens would seek additional funding.

Questions:
Q. Received a letter in the mail for my dual eligible child to move her to Neighborhood Health Plan from United. As a consumer I found the book and the explanation from Medicare offices completely overwhelming and hard to understand. There seems to be a bit of a disdain for a young person who is on Medicare, and that experience has been very difficult, adding one more layer to an already tricky experience. Looking at the Integrated Care initiative, I just caution to think about how the consumer experience may be made better.
A. I think that putting them together is an attempt to do that. In the short run we cannot necessarily solve all of the Medicare problems, but we may try to discuss if a Neighborhood Health Plan duals program is what's best for you. We need to make sure that we set this up right as the Medicare rules are confusing and we don't want to make things worse for people.

Q. Within the ICI CAC, will there be any public comment for the Memorandum of Understanding and/or contracts?
A. The Memorandum of Understanding is already publically available. The contract is not, and we cannot even share it with Neighborhood Health Plan even though Neighborhood Health Plan is party to the contract. There are contracts from other demonstrations available on CMS' website for an example, but we do caution that what is true in one state may not be true here.

Q. There are readiness review documents available - what is the process going on now for that?
A. CMS has a readiness review process, we will have basically two paths: the Medicaid path to check on readiness and a Medicare path, and hopefully those processes will be integrated. That will be alongside the work on the contract, but do expect that work to be

done before a contract.

Q. What is your best guess estimate for timing?
A. Looking at enrollment starting at April 1, 2016.

d. Managed Care Re-Procurement, Deb Florio

State re-procurement we put out a list of all the things we want to buy, all that we are looking for. Right now I have nothing to share for what is in that document, but I want to tease out that I will be here for a few months. Managed care approach to kids and families, CSHCN, new population of adults without children and also for disabled adults (those not in LTC, not duals). Hearing from you all, it helps us think about what we need to do, what we should be asking of those we give money to for taking care of our populations. I say this as we pull together internally a team to think about what to write, what we will ask for in managed care.

There will be some things that we are not doing today that we will ask health plans to do, new contracts will be effective July 2016 yet before July 2016 we will ask the health plans to administer some services such as PASS, HBTS, Respite, amongst others to go in the health plans. On the adult side we will ask health plans to make sure they take of Behavioral Health needs for the SPMI population. In the procurement we will ask for payment methodology, housing initiatives, home stabilization, finally paying for services to keep people in homes. This is an opportunity to do the good things differently.

Q. A few years ago we statutorily empowered Family Court to do the things you are talking about.
A. We want to now pay to help families live in a way that others can. I'll be back in October and November to talk about these things, I will send it along to you all as my stakeholder group. I think you all know what is going on, here as an introduction, and a welcome.

Q. Right now there are two MCOs implementing Medicaid, and wondering, in the last procurement process these two were chosen out of how many who bid for it, and what are we looking for moving forward?
A. Good question, and it was two of two. Many national chains responded to our RFI, but for the procurement it was two of two. I think there is a chance next year we may have more bidders, the hard part is getting done what we want for that cost.

Q. It seems aggressive to have something in place by July 2016, if not ready will you extend?
A. My goal is to have something posted around January, do the best for our members until it is all ready.

Q. Are you going to be asking the plans to do work with CEDARRS?
A. We will ask the plans to contract for the work of three services: PASS, HBTS and Respite. We are augmenting the CEDARR family services, but not bringing them in the plan yet. I have to do a contract amendment in January, so not by then, but by July, perhaps. Especially for families with experiences, that is very helpful.

III. Rules Update – Ann Martino

At the next meeting, Betz Shelov will do a presentation explaining the new process for rules creation. What was a 120-day process is now a six month process. To ensure the system will work appropriately, we will have to look at rules that have not been touched since 2004. We have rules under preparation for the ICI, on Hearings and Appeals, and final rules on transportation (may have another hearing on that), and there are a few other loose ends we will need to get to compliance with federal law. It is a much more complicated process, but it is designed by the Governor's office to prohibit posing unnecessary rules and regulations on the small business sector. Other things are related to programming of the integrated eligibility system (RI Bridges) which will replace In Rhodes and its connection to HSRI. There will be a nexus, which will improve and enhance care management and coordination. The challenge is making sure what is programmed into that system is what we want it to be going forward, rather than the way things are now. We may be reaching out to ask for your input and assistance on the eligibility side to help streamline and make better use of systems in place.

Questions:

Q. On the rules, the draft that went out on category 2 change for levels of care, isn't that also a rules change? Is that a different process?
A. Yes, a category 2 change means seek federal matching funds for a different means of determining eligibility based on levels of care. There are rules in existence now that are archaic. In an ideal world the rules change beforehand we would have been aligned with the category 2 change, we could have just done an incremental approach that was a Band-Aid, but given that it is embedded in an archaic rule, that would not have been efficient.

Q. You mentioned you are working on tight turn-around on eligibility. What is that?
A. For levels of care, there are dates to comment by on the category 2 change, and rules change would be the same thing. As the new changes come through, we will try to have a draft of the rules available on those as well. A BHDHH program outside the scope of Medicaid rule –making.

BHDDH rules tend to be more provider oriented, thus a use very different approach to rule-making.

Q. Reinventing Medicaid also calls for some certification requirements for adult day services and assisted living…?
A. There is a draft of the certification standards out there, and that has a long way to go before we are ready to bring them out, but work is out there. On Adult Day and assisted living side we are working with Michelle Szylin on that, and to see what those services would look like. Additional updates on the certification standards at the next meeting. Right now those standards that exist are those developed by the Department of Elderly Affairs many years ago, those we are looking at now are more modernly based and modeled after programs around the country, more consistent with what is authorized under licensure in RI.

IV. Systems Update – Ann Martino

RI Bridges. In order to come up with rules, we need to discuss systems eligibility programs. Talking with CMS to ensure there is ease of access, and collapse some of the numerous eligibility categories into two or three large ones. As part of that, the change in the criteria for clinical eligibility, there is a marathon writing session underway and long term care, so any volunteers to be a part of that conversation are welcome.

Questions:
Q. RI Bridges, when do you anticipate it launching?
A. I believe the anticipated launch date is July 2016. It is a worker portal we are working hard to modernize the system being used to determine eligibility especially for complex Medicaid.

V. Public Comment

Deb Florio: Want to mention by the next meeting our Medicaid Director has announced that she is leaving the position, last day is October 23. You should all to be aware that we will have new leadership on that point. Want to be sure that you heard it here first.

VI. **Adjourn**: Senator Izzo advises that he is about to wrap up the meeting, but as a preview for our conversation for what we will talk about in October, I invite Brenda from BHDDH to come forward and hand out a copy of a summary for a grant BHDDH has be awarded. She will discuss more next month, but copies of the summary document is going around, or available via email request.